Form **5500**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 01 01 2002 **and ending** 12 31 2002

A This return/report is for:
- (1) a multiemployer plan;
- (2) X a single-employer plan (other than a multiple-employer plan);
- (3) a multiple-employer plan; or
- (4) a DFE (specify) .....

B This return/report is:
- (1) the first return/report filed for the plan;
- (2) an amended return/report;
- (3) the final return/report filed for the plan;
- (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ..... ▶

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ..... ▶

Part II Basic Plan Information -- enter all requested information.

1a Name of plan

INEEL BUSINESS TRAVEL INSURANCE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 04 01 1966

Caution: *A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.*

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace F. Wilkinson Date 07 29 2003

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace F. Wilkinson Date 07 29 2003

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

Official Use Only

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C/O

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

2b Employer Identification Number (EIN) 94 3323797

6) 2c Sponsor's telephone number 208 526 0066

7) 2d Business code (see instructions) 541990

8)

9)

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C/O

3)

4) 3b Administrator's EIN

5)

6) 3c Administrator's telephone number

7)

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN c PN

0 1 0 2 A A 0 2 0 P

Official Use Only

5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3) b EIN

4)

5) c Telephone number

6)

6 Total number of participants at the beginning of the plan year 5189

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants 5221

b Retired or separated participants receiving benefits .....

c Other retired or separated participants entitled to future benefits .....

d Subtotal. Add lines **7a**, **7b**, and **7c** 5221

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....

f Total. Add lines **7d** and **7e** 5221

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) .....

Official Use Only

8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b X Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4Q

9a Plan funding arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

1) R (Retirement Plan Information)

2) T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ..... ▶

3) B (Actuarial Information)

4) E (ESOP Annual Information)

5) SSA (Separated Vested Participant Information)

b Financial Schedules

1) H (Financial Information)

2) I (Financial Information--Small Plan)

3) X 001 A (Insurance Information)

4) C (Service Provider Information)

5) D (DFE/Participating Plan Information)

6) G (Financial Transaction Schedules)

7) P (Trust Fiduciary Information)

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning. 01 01 2002 and ending 12 31 2002

A Name of plan
INEEL Business Travel Insurance Plan

B Three-digit plan number ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
Bechtel BWXT Idaho, LLC

D **Employer Identification Number**
94 3323797

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions**

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier
TRANSAMERICA OCCIDENTAL LIFE INSURANCE

(b) EIN 95 1060502 (c) NAIC code 67121

(d) Contract or identification number 05228081

(e) Approximate number of persons covered at end of policy or contract year 5221

Policy or contract year (f) From 01 01 2002 (g) To 12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals	Total amount of commissions paid	Total fees paid / amount
	0	

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Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

Official Use Only

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates

▶

b Premiums paid to carrier .....

c Premiums due but unpaid at the end of the year .....

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....

Specify nature of costs

▶

e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)

▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ..... ▶

Official Use Only

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

(1) deposit administration (2) immediate participation guarantee (3) guaranteed investment

(4) other (specify below)

▶

b Balance at the end of the previous year .....

c Additions:

(1) Contributions deposited during the year .....

(2) Dividends and credits .....

(3) Interest credited during the year .....

(4) Transferred from separate account .....

(5) Other (specify below) .....

▶

(6) Total additions .....

d Total of balance and additions (add **b** and **c***(6)*) .....

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year .....

(2) Administration charge made by carrier .....

(3) Transferred to separate account .....

(4) Other (specify below) .....

▶

(5) Total deductions .....

f Balance at the end of the current year (subtract **e***(5)* from **d**) .....

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	Dental	(c)	Vision	(d)	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	Supplemental unemployment	(h)	Prescription drug
(i)	Stop loss (large deductible)	(j)	HMO contract	(k)	PPO contract	(l)	Indemnity contract

(m) X Other (specify below)

▶ TRAVEL ACCIDENTAL DEATH & DISMEMBER

8 Experience-rated contracts

a Premiums:

(1) Amount received .....

(2) Increase (decrease) in amount due but unpaid .....

(3) Increase (decrease) in unearned premium reserve .....

(4) Earned *((1) + (2) - (3))* .....

b Benefit charges:

(1) Claims paid .....

(2) Increase (decrease) in claim reserves .....

(3) Incurred claims (add *(1)* and *(2)*) .....

(4) Claims charged .....

Official Use Only

c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions .....

(B) Administrative service or other fees .....

(C) Other specific acquisition costs .....

(D) Other expenses .....

(E) Taxes .....

(F) Charges for risks or other contingencies

(G) Other retention charges .....

(H) Total retention .....

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.) ...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement .....

(2) Claim reserves .....

(3) Other reserves .....

e Dividends or retroactive rate refunds due.
(Do not include amount entered in c(2).) .....

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier 3300

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount .....
Specify nature of costs below

Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 01 01 2002 **and ending** 12 31 2002

A This return/report is for:
- (1) a multiemployer plan;
- (2) X a single-employer plan (other than a multiple-employer plan);
- (3) a multiple-employer plan; or
- (4) a DFE (specify) .....

B This return/report is:
- (1) the first return/report filed for the plan;
- (2) an amended return/report;
- (3) the final return/report filed for the plan;
- (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ..... ▶

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ..... ▶

Part II Basic Plan Information -- enter all requested information.

1a Name of plan

INEEL FLEXIBLE BENEFITS PLAN

1b Three-digit plan number (PN) ▶ 506

1c Effective date of plan 01 01 1989

Caution: *A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.*

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace F. Wilkinson Date 07 29 2003

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace F. Wilkinson Date 07 29 2003

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

Official Use Only

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C / O

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

2b Employer Identification Number (EIN) 94 3323797

6) 2c Sponsor's telephone number 208 526 0066

7) 2d Business code (see instructions) 541990

8)

9)

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C / O

3)

4) 3b Administrator's EIN

5)

6) 3c Administrator's telephone number

7)

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN c PN

0 1 0 2 A A 0 2 0 P

Official Use Only

5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3) b EIN

4)

5) c Telephone number

6)

6 Total number of participants at the beginning of the plan year 2118

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants 2069

b Retired or separated participants receiving benefits .....

c Other retired or separated participants entitled to future benefits .....

d Subtotal. Add lines **7a**, **7b**, and **7c** 2069

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....

f Total. Add lines **7d** and **7e** 2069

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) .....

Official Use Only

8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b X Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4Q

9a Plan funding arrangement (check all that apply)

(1) Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) X General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) X General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

1) R (Retirement Plan Information)

2) T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ..... ▶

3) B (Actuarial Information)

4) E (ESOP Annual Information)

5) SSA (Separated Vested Participant Information)

b Financial Schedules

1) H (Financial Information)

2) I (Financial Information--Small Plan)

3) A (Insurance Information)

4) X C (Service Provider Information)

5) D (DFE/Participating Plan Information)

6) G (Financial Transaction Schedules)

7) P (Trust Fiduciary Information)

0 1 0 2 A A 0 4 0 R

SCHEDULE C (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Service Provider Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ File as an attachment to Form 5500.

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning. 01 01 2002 and ending 12 31 2002

A Name of plan
INEEL Flexible Benefits Plan

B Three-digit plan number ▶ 506

C Plan sponsor's name as shown on line 2a of Form 5500
Bechtel BWXT Idaho, LLC

D Employer Identification Number

Part I Service Provider Information (see instructions)

1 Enter the total dollar amount of compensation paid by the plan to all persons, other than those listed below, who received compensation during the plan year: .....

2 On the first item below list the contract administrator, if any, as defined in the instructions. On the other items, list service providers in descending order of the compensation they received for the services rendered during the plan year. List only the top 40. 103-12 IEs should enter N/A in (c) and (d).

(a) Name
AETNA US HEALTHCARE

(b) Employer identification number (see instructions) 06 6033492

(c) Official plan position Contract administrator

(d) Relationship to employer, employee organization, or person known to be a party-in-interest CLAIMS PROCESSING

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan 94942

(g) Nature of service code(s) (see instructions) 12

(a) Name

(b) Employer identification number (see instructions)

(c) Official plan position

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s) (see instructions)

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Official Use Only

(a) Name

(b) Employer identification number (see instructions)

(c) Official plan position

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s) (see instructions)

(a) Name

(b) Employer identification number (see instructions)

(c) Official plan position

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s) (see instructions)

(a) Name

(b) Employer identification number (see instructions)

(c) Official plan position

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s) (see instructions)

(a) Name

(b) Employer identification number (see instructions)

(c) Official plan position

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s) (see instructions)

Official Use Only

Part II **Termination Information on Accountants and Enrolled Actuaries** (see instructions)

(a)
Name

(b) EIN

(c) Position

(d)
Address

(e) Telephone No.

EXPLANATION

(a)
Name

(b) EIN

(c) Position

(d)
Address

(e) Telephone No.

EXPLANATION

Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 01 01 2002 **and ending** 12 31 2002

A This return/report is for: (1) a multiemployer plan; (3) a multiple-employer plan; or
(2) X a single-employer plan (other than a multiple-employer plan); (4) a DFE (specify) .....

B This return/report is: (1) the first return/report filed for the plan; (3) the final return/report filed for the plan;
(2) an amended return/report; (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ..... ▶

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ..... ▶

Part II Basic Plan Information -- enter all requested information.

1a Name of plan

INEEL VISION CARE PLAN

1b Three-digit plan number (PN) ▶ 509

1c Effective date of plan 01 01 1993

Caution: *A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.*

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace Wilkinson Date 07 29 2003

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace Wilkinson Date 07 29 2003

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

Official Use Only

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C / O

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

6)

7)

8)

9)

2b Employer Identification Number (EIN) 94 3323797

2c Sponsor's telephone number 208 526 0066

2d Business code (see instructions) 541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C / O

3)

4)

5)

6)

7)

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

0 1 0 2 A A 0 2 0 P

Official Use Only

5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3) b EIN

4)

5) c Telephone number

6)

6 Total number of participants at the beginning of the plan year 1363

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants 1403

b Retired or separated participants receiving benefits 14

c Other retired or separated participants entitled to future benefits .....

d Subtotal. Add lines **7a**, **7b**, and **7c** 1417

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....

f Total. Add lines **7d** and **7e** 1417

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) .....

Official Use Only

8 Benefits provided under the plan (complete **8a** and **8b**, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b X Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4E

9a Plan funding arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

1) R (Retirement Plan Information)

2) T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ..... ▶

3) B (Actuarial Information)

4) E (ESOP Annual Information)

5) SSA (Separated Vested Participant Information)

b Financial Schedules

1) H (Financial Information)

2) I (Financial Information--Small Plan)

3) X 001 A (Insurance Information)

4) C (Service Provider Information)

5) D (DFE/Participating Plan Information)

6) G (Financial Transaction Schedules)

7) P (Trust Fiduciary Information)

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning. 01 01 2002 and ending 12 31 2002

A Name of plan
INEEL VISION CARE PLAN

B Three-digit plan number ▶ 509

C Plan sponsor's name as shown on line 2a of Form 5500
BECHTEL BWXT IDAHO, LLC

D Employer Identification Number
94 3323797

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier
VISION SERVICE PLAN

(b) EIN 82 0339119 (c) NAIC code 47783

(d) Contract or identification number 12154777

(e) Approximate number of persons covered at end of policy or contract year 1400

Policy or contract year (f) From 01 01 2002 (g) To 12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

	Total amount of commissions paid	Total fees paid / amount
Totals		

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Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

Official Use Only

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates

▶

b Premiums paid to carrier .....

c Premiums due but unpaid at the end of the year .....

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....

Specify nature of costs

▶

e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)

▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ..... ▶

Official Use Only

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

(1) deposit administration (2) immediate participation guarantee (3) guaranteed investment

(4) other (specify below)

▶

b Balance at the end of the previous year .....

c Additions:

(1) Contributions deposited during the year .....

(2) Dividends and credits .....

(3) Interest credited during the year .....

(4) Transferred from separate account .....

(5) Other (specify below) .....

▶

(6) Total additions .....

d Total of balance and additions (add **b** and **c***(6)*) .....

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year .....

(2) Administration charge made by carrier .....

(3) Transferred to separate account .....

(4) Other (specify below) .....

▶

(5) Total deductions .....

f Balance at the end of the current year (subtract **e***(5)* from **d**) .....

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	Dental	(c)	X Vision	(d)	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	Supplemental unemployment	(h)	Prescription drug
(i)	Stop loss (large deductible)	(j)	HMO contract	(k)	PPO contract	(l)	Indemnity contract
(m)	Other (specify below)						

▶

8 Experience-rated contracts

a Premiums:

(1) Amount received .....

(2) Increase (decrease) in amount due but unpaid .....

(3) Increase (decrease) in unearned premium reserve .....

(4) Earned *((1) + (2) - (3))* .....

b Benefit charges:

(1) Claims paid .....

(2) Increase (decrease) in claim reserves .....

(3) Incurred claims (add *(1)* and *(2)*) .....

(4) Claims charged .....

Official Use Only

c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions .....

(B) Administrative service or other fees .....

(C) Other specific acquisition costs .....

(D) Other expenses .....

(E) Taxes .....

(F) Charges for risks or other contingencies

(G) Other retention charges .....

(H) Total retention .....

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.) ...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement .....

(2) Claim reserves .....

(3) Other reserves .....

e Dividends or retroactive rate refunds due.
(Do not include amount entered in c(2).) .....

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier 305311

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount .....
Specify nature of costs below

Form **5500**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 10 01 2002 **and ending** 09 30 2003

A This return/report is for:
- (1) ☐ a multiemployer plan;
- (2) ☒ a single-employer plan (other than a multiple-employer plan);
- (3) ☐ a multiple-employer plan; or
- (4) ☐ a DFE (specify) .....

B This return/report is:
- (1) ☐ the first return/report filed for the plan;
- (2) ☐ an amended return/report;
- (3) ☐ the final return/report filed for the plan;
- (4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ..... ▶ ☐

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ..... ▶ ☐

Part II Basic Plan Information – enter all requested information.

1a Name of plan

INEEL DENTAL CARE PLAN

1b Three-digit plan number (PN) ▶ 510

1c Effective date of plan 01 01 1995

Caution: *A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.*

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace F. Wilkinson Date 04 20 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace F. Wilkinson Date 04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

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Official Use Only

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C/O CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

2b Employer Identification Number (EIN) 94 3323797

6) 2c Sponsor's telephone number 208 526 0066

7) 2d Business code (see instructions) 541990

8)

9)

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C/O

3)

4) 3b Administrator's EIN

5)

6) 3c Administrator's telephone number

7)

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN c PN

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Official Use Only

5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year 4893

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants 4767

b Retired or separated participants receiving benefits 205

c Other retired or separated participants entitled to future benefits .....

d Subtotal. Add lines 7a, 7b, and 7c 4972

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....

f Total. Add lines 7d and 7e 4972

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) .....

Official Use Only

8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b X Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4D

9a Plan funding arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

1) R (Retirement Plan Information)

2) T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ..... ▶

3) B (Actuarial Information)

4) E (ESOP Annual Information)

5) SSA (Separated Vested Participant Information)

b Financial Schedules

1) H (Financial Information)

2) I (Financial Information--Small Plan)

3) X 002 A (Insurance Information)

4) C (Service Provider Information)

5) D (DFE/Participating Plan Information)

6) G (Financial Transaction Schedules)

7) P (Trust Fiduciary Information)

0 1 0 2 A A 0 4 0 R

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2003

A Name of plan
INEEL DENTAL CARE PLAN

B Three-digit plan number ▶ 510

C Plan sponsor's name as shown on line 2a of Form 5500
BECHTEL BWXT IDAHO, LLC

D **Employer Identification Number**
94 3323797

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions**
Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier
DELTA DENTAL PLAN OF CALIFORNIA

(b) EIN 94 1461312 (c) NAIC code

(d) Contract or identification number 5440

(e) Approximate number of persons covered at end of policy or contract year 4980

Policy or contract year (f) From 01 01 2002 (g) To 12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals	Total amount of commissions paid	Total fees paid / amount
	0	0

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Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

Official Use Only

Part II **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates

▶

b Premiums paid to carrier .....

c Premiums due but unpaid at the end of the year .....

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....

Specify nature of costs

▶

e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)

▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ..... ▶

Official Use Only

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

(1) deposit administration (2) immediate participation guarantee (3) guaranteed investment

(4) other (specify below)

▶

b Balance at the end of the previous year .....

c Additions:

(1) Contributions deposited during the year .....

(2) Dividends and credits .....

(3) Interest credited during the year .....

(4) Transferred from separate account .....

(5) Other (specify below) .....

▶

(6) Total additions .....

d Total of balance and additions (add b and c*(6)*) .....

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year .....

(2) Administration charge made by carrier .....

(3) Transferred to separate account .....

(4) Other (specify below) .....

▶

(5) Total deductions .....

f Balance at the end of the current year (subtract e*(5)* from d) .....

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	X Dental	(c)	Vision	(d)	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	Supplemental unemployment	(h)	Prescription drug
(i)	Stop loss (large deductible)	(j)	HMO contract	(k)	PPO contract	(l)	Indemnity contract
(m)	Other (specify below)						

▶

8 Experience-rated contracts

a Premiums:

(1) Amount received 4336242

(2) Increase (decrease) in amount due but unpaid .....

(3) Increase (decrease) in unearned premium reserve .....

(4) Earned *((1) + (2) - (3))* 4336242

b Benefit charges:

(1) Claims paid 3782551

(2) Increase (decrease) in claim reserves .....

(3) Incurred claims (add *(1)* and *(2)*) 3782551

(4) Claims charged .....

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Official Use Only

c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions .....

(B) Administrative service or other fees 356439

(C) Other specific acquisition costs .....

(D) Other expenses .....

(E) Taxes .....

(F) Charges for risks or other contingencies

(G) Other retention charges .....

(H) Total retention 356439

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.) ...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement .....

(2) Claim reserves 400000

(3) Other reserves .....

e Dividends or retroactive rate refunds due.
(Do not include amount entered in c(2).) .....

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier .....

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount .....
Specify nature of costs below

Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 10 01 2002 **and ending** 09 30 2003

A This return/report is for: (1) a multiemployer plan; (3) a multiple-employer plan; or
(2) X a single-employer plan (other than a multiple-employer plan); (4) a DFE (specify) .....

B This return/report is: (1) the first return/report filed for the plan; (3) the final return/report filed for the plan;
(2) an amended return/report; (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ..... ▶

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ..... ▶

Part II Basic Plan Information – enter all requested information.

1a Name of plan

INEEL HEALTH CARE PLAN

1b Three-digit plan number (PN) ▶ 504

1c Effective date of plan 07 01 1966

Caution: *A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.*

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace F Wilkinson Date 04 20 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace F Wilkinson Date 04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

Official Use Only

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C/O CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

2b Employer Identification Number (EIN) 94 3323797

6) 2c Sponsor's telephone number 208 526 0066

7) 2d Business code (see instructions) 541990

8)

9)

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C/O

3)

4) 3b Administrator's EIN

5)

6) 3c Administrator's telephone number

7)

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN c PN

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Official Use Only

5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3) b EIN

4)

5) c Telephone number

6)

6 Total number of participants at the beginning of the plan year 5964

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants 4750

b Retired or separated participants receiving benefits 1084

c Other retired or separated participants entitled to future benefits .....

d Subtotal. Add lines **7a**, **7b**, and **7c** 5834

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....

f Total. Add lines **7d** and **7e** 5834

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) .....

Official Use Only

8 Benefits provided under the plan (complete **8a** and **8b**, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b X Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4A

9a Plan funding arrangement (check all that apply)

(1) X Insurance
(2) Code section 412(i) insurance contracts
(3) Trust
(4) X General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) X Insurance
(2) Code section 412(i) insurance contracts
(3) Trust
(4) X General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

1) R (Retirement Plan Information)
2) T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ..... ▶

3) B (Actuarial Information)
4) E (ESOP Annual Information)
5) SSA (Separated Vested Participant Information)

b Financial Schedules

1) H (Financial Information)
2) I (Financial Information--Small Plan)
3) X 001- A (Insurance Information)
4) X C (Service Provider Information)
5) D (DFE/Participating Plan Information)
6) G (Financial Transaction Schedules)
7) P (Trust Fiduciary Information)

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2003

A Name of plan
INEEL HEALTH CARE PLAN

B Three-digit plan number ▶ 504

C Plan sponsor's name as shown on line 2a of Form 5500
BECHTEL BWXT IDAHO, LLC

D **Employer Identification Number**
94 3323797

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions**
Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier
VISION SERVICE PLAN

(b) EIN 82 0339119 (c) NAIC code 47783

(d) Contract or identification number 12165723

(e) Approximate number of persons covered at end of policy or contract year 5967

Policy or contract year (f) From 01 01 2002 (g) To 12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals	Total amount of commissions paid	Total fees paid / amount
	0	0

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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

Official Use Only

Part II **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates

▶

b Premiums paid to carrier .....

c Premiums due but unpaid at the end of the year .....

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....

Specify nature of costs

▶

e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)

▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ..... ▶

Official Use Only

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

(1) deposit administration (2) immediate participation guarantee (3) guaranteed investment

(4) other (specify below)

▶

b Balance at the end of the previous year .....

c Additions:

(1) Contributions deposited during the year .....

(2) Dividends and credits .....

(3) Interest credited during the year .....

(4) Transferred from separate account .....

(5) Other (specify below) .....

▶

(6) Total additions .....

d Total of balance and additions (add **b** and **c***(6)*) .....

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year .....

(2) Administration charge made by carrier .....

(3) Transferred to separate account .....

(4) Other (specify below) .....

▶

(5) Total deductions .....

f Balance at the end of the current year (subtract **e***(5)* from **d**) .....

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	Dental	(c)	X Vision	(d)	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	Supplemental unemployment	(h)	Prescription drug
(i)	Stop loss (large deductible)	(j)	HMO contract	(k)	PPO contract	(l)	Indemnity contract
(m)	Other (specify below)						

▶

8 Experience-rated contracts

a Premiums:

(1) Amount received .....

(2) Increase (decrease) in amount due but unpaid .....

(3) Increase (decrease) in unearned premium reserve .....

(4) Earned *((1) + (2) - (3))* .....

b Benefit charges:

(1) Claims paid .....

(2) Increase (decrease) in claim reserves .....

(3) Incurred claims (add *(1)* and *(2)*) .....

(4) Claims charged .....

Official Use Only

c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions .....

(B) Administrative service or other fees .....

(C) Other specific acquisition costs .....

(D) Other expenses .....

(E) Taxes .....

(F) Charges for risks or other contingencies

(G) Other retention charges .....

(H) Total retention .....

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.) ...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement .....

(2) Claim reserves .....

(3) Other reserves .....

e Dividends or retroactive rate refunds due.
(Do not include amount entered in c(2).) .....

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier 457298

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount .....
Specify nature of costs below

SCHEDULE C (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Service Provider Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ **File as an attachment to Form 5500.**

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2003

A Name of plan

INEEL HEALTH CARE PLAN

B Three-digit plan number ▶ 504

C Plan sponsor's name as shown on line 2a of Form 5500

BECHTEL BWXT IDAHO, LLC

D Employer Identification Number

94 3323797

Part I Service Provider Information (see instructions)

1 Enter the total dollar amount of compensation paid by the plan to all persons, other than those listed below, who received compensation during the plan year: .....

2 On the first item below list the contract administrator, if any, as defined in the instructions. On the other items, list service providers in descending order of the compensation they received for the services rendered during the plan year. List only the top 40. 103-12 IEs should enter N/A in (c) and (d).

(a) Name

AETNA US HEALTHCARE

(b) Employer identification number (see instructions) 06 6033492

(c) Official plan position — Contract administrator

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan 1801985

(g) Nature of service code(s) (see instructions) 1 2

(a) Name

ECKERD HEALTH SERVICES

(b) Employer identification number (see instructions) 51 0353040

(c) Official plan position — CONTRACT ADMINISTRATOR

(d) Relationship to employer, employee organization, or person known to be a party-in-interest — CLAIMS PROCESSING

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan 40631

(g) Nature of service code(s) (see instructions) 12

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Official Use Only

(a) Name
CIGNA BEHAVIORAL HEALTH

(b) Employer identification number (see instructions) 41 1648670

(c) Official plan position CONTRACT ADMINISTRATOR

(d) Relationship to employer, employee organization, or person known to be a party-in-interest CLAIMS PROCESSING

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan 179771

(g) Nature of service code(s) (see instructions) 12

(a) Name

(b) Employer identification number (see instructions)

(c) Official plan position

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s) (see instructions)

(a) Name

(b) Employer identification number (see instructions)

(c) Official plan position

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s) (see instructions)

(a) Name

(b) Employer identification number (see instructions)

(c) Official plan position

(d) Relationship to employer, employee organization, or person known to be a party-in-interest

(e) Gross salary or allowances paid by plan

(f) Fees and commissions paid by plan

(g) Nature of service code(s) (see instructions)

Part II **Termination Information on Accountants and Enrolled Actuaries** (see instructions)

Official Use Only

(a)
Name

(b) EIN

(c) Position

(d)
Address

(e) Telephone No.

EXPLANATION

(a)
Name

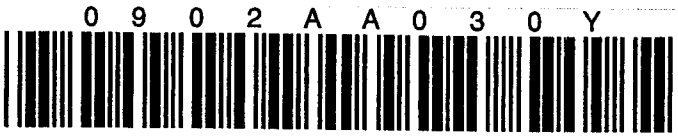
(b) EIN

(c) Position

(d)
Address

(e) Telephone No.

EXPLANATION



Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 10 01 2002 **and ending** 09 30 2003

A This return/report is for:
- (1) a multiemployer plan;
- (2) X a single-employer plan (other than a multiple-employer plan);
- (3) a multiple-employer plan; or
- (4) a DFE (specify) .....

B This return/report is:
- (1) the first return/report filed for the plan;
- (2) an amended return/report;
- (3) the final return/report filed for the plan;
- (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ..... ▶

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ..... ▶

Part II Basic Plan Information – enter all requested information.

1a Name of plan

SEVERANCE PAY PLAN

1b Three-digit plan number (PN) ▶ 507

1c Effective date of plan 10 01 1987

Caution: *A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.*

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace Wilkinson Date 04 20 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace Wilkinson Date 04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

Official Use Only

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C/O CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

6)

7)

8)

9)

2b Employer Identification Number (EIN) 94 3323797

2c Sponsor's telephone number 208 526 0066

2d Business code (see instructions) 541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C/O

3)

4)

5)

6)

7)

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

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Official Use Only

5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year 5080

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants 5004

b Retired or separated participants receiving benefits .....

c Other retired or separated participants entitled to future benefits .....

d Subtotal. Add lines **7a**, **7b**, and **7c** 5004

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....

f Total. Add lines **7d** and **7e** 5004

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) .....

0 1 0 2 A A 0 3 0 Q

Official Use Only

8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b X Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4I

9a Plan funding arrangement (check all that apply)

(1) Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) X General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) X General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

1) R (Retirement Plan Information)

2) T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ..... ▶

3) B (Actuarial Information)

4) E (ESOP Annual Information)

5) SSA (Separated Vested Participant Information)

b Financial Schedules

1) H (Financial Information)

2) I (Financial Information--Small Plan)

3) A (Insurance Information)

4) C (Service Provider Information)

5) D (DFE/Participating Plan Information)

6) G (Financial Transaction Schedules)

7) P (Trust Fiduciary Information)

0 1 0 2 A A 0 4 0 R

Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 10 01 2002 **and ending** 09 30 2003

A This return/report is for:
- (1) a multiemployer plan;
- (2) X a single-employer plan (other than a multiple-employer plan);
- (3) a multiple-employer plan; or
- (4) a DFE (specify) .....

B This return/report is:
- (1) the first return/report filed for the plan;
- (2) an amended return/report;
- (3) the final return/report filed for the plan;
- (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ..... ▶

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ..... ▶

Part II Basic Plan Information -- enter all requested information.

1a Name of plan

INEEL ACCIDENTAL DEATH AND DISMEMBERMENT PLAN

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 09 01 1966

Caution: *A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.*

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace F. Wilkinson Date 04 20 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace F. Wilkinson Date 04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

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Official Use Only

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C/O CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

6)

7)

8)

9)

2b Employer Identification Number (EIN) 94 3323797

2c Sponsor's telephone number 208 526 0066

2d Business code (see instructions) 541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C/O

3)

4)

5)

6)

7)

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

0 1 0 2 A A 0 2 0 P

Official Use Only

5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3) b EIN

4)

5) c Telephone number

6)

6 Total number of participants at the beginning of the plan year 3872

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants 3821

b Retired or separated participants receiving benefits .....

c Other retired or separated participants entitled to future benefits .....

d Subtotal. Add lines **7a**, **7b**, and **7c** 3821

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....

f Total. Add lines **7d** and **7e** 3821

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) .....

Official Use Only

8 Benefits provided under the plan (complete **8a** and **8b**, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b X Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4Q

9a Plan funding arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

1) **R** (Retirement Plan Information)

2) **T** (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ..... ▶

3) **B** (Actuarial Information)

4) **E** (ESOP Annual Information)

5) **SSA** (Separated Vested Participant Information)

b Financial Schedules

1) **H** (Financial Information)

2) **I** (Financial Information--Small Plan)

3) X 001 **A** (Insurance Information)

4) **C** (Service Provider Information)

5) **D** (DFE/Participating Plan Information)

6) **G** (Financial Transaction Schedules)

7) **P** (Trust Fiduciary Information)

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2003

A Name of plan
INEEL ACCIDENTAL DEATH AND DISMEMBERMENT PLAN

B Three-digit plan number ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
BECHTEL BWXT IDAHO, LLC

D Employer Identification Number
94 3323797

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions**

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier
TRANSAMERICA OCCIDENTAL LIFE INSURANCE

(b) EIN 95 1060502 **(c)** NAIC code 67121

(d) Contract or identification number 05228082

(e) Approximate number of persons covered at end of policy or contract year 3993

Policy or contract year **(f)** From 01 01 2002 **(g)** To 12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

	Total amount of commissions paid	Total fees paid / amount
Totals	0	0

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Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

Official Use Only

Part II **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates

▶

b Premiums paid to carrier .....

c Premiums due but unpaid at the end of the year .....

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....

Specify nature of costs

▶

e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)

▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ..... ▶

Official Use Only

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

(1) deposit administration (2) immediate participation guarantee (3) guaranteed investment

(4) other (specify below)

▶

b Balance at the end of the previous year .....

c Additions:

(1) Contributions deposited during the year .....

(2) Dividends and credits .....

(3) Interest credited during the year .....

(4) Transferred from separate account .....

(5) Other (specify below) .....

▶

(6) Total additions .....

d Total of balance and additions (add **b** and **c***(6)*) .....

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year .....

(2) Administration charge made by carrier .....

(3) Transferred to separate account .....

(4) Other (specify below) .....

▶

(5) Total deductions .....

f Balance at the end of the current year (subtract **e***(5)* from **d**) .....

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	Dental	(c)	Vision	(d)	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	Supplemental unemployment	(h)	Prescription drug
(i)	Stop loss (large deductible)	(j)	HMO contract	(k)	PPO contract	(l)	Indemnity contract

(m) X Other (specify below)

▶ ACCIDENTAL DEATH AND DISMEMBERMENT

8 Experience-rated contracts

a Premiums:

(1) Amount received .....

(2) Increase (decrease) in amount due but unpaid .....

(3) Increase (decrease) in unearned premium reserve .....

(4) Earned *((1) + (2) - (3))* .....

b Benefit charges:

(1) Claims paid .....

(2) Increase (decrease) in claim reserves .....

(3) Incurred claims (add *(1)* and *(2)*) .....

(4) Claims charged .....

Official Use Only

c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions .....

(B) Administrative service or other fees .....

(C) Other specific acquisition costs .....

(D) Other expenses .....

(E) Taxes .....

(F) Charges for risks or other contingencies

(G) Other retention charges .....

(H) Total retention .....

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.) ...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement .....

(2) Claim reserves .....

(3) Other reserves .....

e Dividends or retroactive rate refunds due.
(Do not include amount entered in c(2).) .....

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier .....

461474

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount .....
Specify nature of costs below

Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 10 01 2002 **and ending** 09 30 2003

A This return/report is for:
- (1) a multiemployer plan;
- (2) X a single-employer plan (other than a multiple-employer plan);
- (3) a multiple-employer plan; or
- (4) a DFE (specify) .....

B This return/report is:
- (1) the first return/report filed for the plan;
- (2) an amended return/report;
- (3) the final return/report filed for the plan;
- (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ..... ▶

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ..... ▶

Part II Basic Plan Information – enter all requested information.

1a Name of plan

INEEL LONG TERM DISABILITY INSURANCE PLAN

1b Three-digit plan number (PN) ▶ 505

1c Effective date of plan 12 01 1968

Caution: *A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.*

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace F. Wilkinson Date 04 20 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace F. Wilkinson Date 04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

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U.S. GOVERNMENT PRINTING OFFICE:2003-497-703

Official Use Only

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C/O CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

2b Employer Identification Number (EIN) 94 3323797

6) 2c Sponsor's telephone number 208 526 0066

7) 2d Business code (see instructions) 541990

8)

9)

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C/O

3)

4) 3b Administrator's EIN

5)

6) 3c Administrator's telephone number

7)

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN c PN

0 1 0 2 A A 0 2 0 P

Official Use Only

5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3) b EIN

4)

5) c Telephone number

6)

6 Total number of participants at the beginning of the plan year 3980

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants 3781

b Retired or separated participants receiving benefits 77

c Other retired or separated participants entitled to future benefits .....

d Subtotal. Add lines **7a**, **7b**, and **7c** 3858

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....

f Total. Add lines **7d** and **7e** 3858

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) .....

Official Use Only

8 Benefits provided under the plan (complete **8a** and **8b**, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b X Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4H

9a Plan funding arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

1) R (Retirement Plan Information)

2) T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ..... ▶

3) B (Actuarial Information)

4) E (ESOP Annual Information)

5) SSA (Separated Vested Participant Information)

b Financial Schedules

1) H (Financial Information)

2) I (Financial Information--Small Plan)

3) X 001 A (Insurance Information)

4) C (Service Provider Information)

5) D (DFE/Participating Plan Information)

6) G (Financial Transaction Schedules)

7) P (Trust Fiduciary Information)

0 1 0 2 A A 0 4 0 R

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2003

A Name of plan
INEEL LONG TERM DISABILITY INSURANCE PLAN

B Three-digit plan number ▶ 505

C Plan sponsor's name as shown on line 2a of Form 5500
BECHTEL BWXT IDAHO, LLC

D **Employer Identification Number**
94 3323797

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions**

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier
CIGNA LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN 23 1503749 (c) NAIC code 65498

(d) Contract or identification number LK 008044

(e) Approximate number of persons covered at end of policy or contract year 3960

Policy or contract year (f) From 01 01 2002 (g) To 12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

	Total amount of commissions paid	Total fees paid / amount
Totals	0	0

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Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

Official Use Only

Part II **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates

▶

b Premiums paid to carrier .....

c Premiums due but unpaid at the end of the year .....

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....

Specify nature of costs

▶

e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)

▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ..... ▶

Official Use Only

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

(1) deposit administration (2) immediate participation guarantee (3) guaranteed investment

(4) other (specify below)

▶

b Balance at the end of the previous year .....

c Additions:

(1) Contributions deposited during the year .....

(2) Dividends and credits .....

(3) Interest credited during the year .....

(4) Transferred from separate account .....

(5) Other (specify below) .....

▶

(6) Total additions .....

d Total of balance and additions (add **b** and **c***(6)*) .....

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year .....

(2) Administration charge made by carrier .....

(3) Transferred to separate account .....

(4) Other (specify below) .....

▶

(5) Total deductions .....

f Balance at the end of the current year (subtract **e***(5)* from **d**) .....

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	Dental	(c)	Vision	(d)	Life Insurance
(e)	Temporary disability (accident and sickness)	(f) X	Long-term disability	(g)	Supplemental unemployment	(h)	Prescription drug
(i)	Stop loss (large deductible)	(j)	HMO contract	(k)	PPO contract	(l)	Indemnity contract
(m)	Other (specify below)						

▶

8 Experience-rated contracts

a Premiums:

(1) Amount received .....

(2) Increase (decrease) in amount due but unpaid .....

(3) Increase (decrease) in unearned premium reserve .....

(4) Earned *((1) + (2) - (3))* .....

b Benefit charges:

(1) Claims paid .....

(2) Increase (decrease) in claim reserves .....

(3) Incurred claims (add *(1)* and *(2)*) .....

(4) Claims charged .....

Official Use Only

c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions .....

(B) Administrative service or other fees .....

(C) Other specific acquisition costs .....

(D) Other expenses .....

(E) Taxes .....

(F) Charges for risks or other contingencies

(G) Other retention charges .....

(H) Total retention .....

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.) ...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement .....

(2) Claim reserves .....

(3) Other reserves .....

e Dividends or retroactive rate refunds due.
(Do not include amount entered in c(2).) .....

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier 1322858

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount .....
Specify nature of costs below

Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 10 01 2002 **and ending** 09 30 2003

A This return/report is for:
- (1) a multiemployer plan;
- (2) X a single-employer plan (other than a multiple-employer plan);
- (3) a multiple-employer plan; or
- (4) a DFE (specify) .....

B This return/report is:
- (1) the first return/report filed for the plan;
- (2) an amended return/report;
- (3) the final return/report filed for the plan;
- (4) a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ..... ▶

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ..... ▶

Part II Basic Plan Information -- enter all requested information.

1a Name of plan

INEEL LIFE INSURANCE PLAN

1b Three-digit plan number (PN) ▶ 503

1c Effective date of plan 07 01 1966

Caution: *A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.*

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace F. Wilkinson Date 04 20 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace F. Wilkinson Date 04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

Official Use Only

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C/O CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

6)

7)

8)

9)

2b Employer Identification Number (EIN) 94 3323797

2c Sponsor's telephone number 208 526 0066

2d Business code (see instructions) 541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C/O

3)

4)

5)

6)

7)

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

0 1 0 2 A A 0 2 0 P

Official Use Only

5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3) b EIN

4)

5) c Telephone number

6)

6 Total number of participants at the beginning of the plan year 6539

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants 4994

b Retired or separated participants receiving benefits .....

c Other retired or separated participants entitled to future benefits 1465

d Subtotal. Add lines **7a**, **7b**, and **7c** 6459

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....

f Total. Add lines **7d** and **7e** 6459

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) .....

Official Use Only

8 Benefits provided under the plan (complete **8a** and **8b**, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b X Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4B

9a Plan funding arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

1) R (Retirement Plan Information)

2) T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ..... ▶

3) B (Actuarial Information)

4) E (ESOP Annual Information)

5) SSA (Separated Vested Participant Information)

b Financial Schedules

1) H (Financial Information)

2) I (Financial Information--Small Plan)

3) X 003 A (Insurance Information)

4) C (Service Provider Information)

5) D (DFE/Participating Plan Information)

6) G (Financial Transaction Schedules)

7) P (Trust Fiduciary Information)

0 1 0 2 A A 0 4 0 R

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2003

A Name of plan
INEEL LIFE INSURANCE PLAN

B Three-digit plan number ▶ 503

C Plan sponsor's name as shown on line 2a of Form 5500
BECHTEL BWXT IDAHO, LLC

D Employer Identification Number
94 3323797

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions**
Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier
PRUDENTIAL FINANCIAL

(b) EIN 22 1211670 **(c)** NAIC code 68241

(d) Contract or identification number 24927-1

(e) Approximate number of persons covered at end of policy or contract year 3223

Policy or contract year **(f)** From 01 01 2002 **(g)** To 12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals	Total amount of commissions paid	Total fees paid / amount
	0	0

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Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

Official Use Only

Part II **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates

▶

b Premiums paid to carrier .....

c Premiums due but unpaid at the end of the year .....

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....

Specify nature of costs

▶

e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)

▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ..... ▶

Official Use Only

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

(1) deposit administration (2) immediate participation guarantee (3) guaranteed investment

(4) other (specify below)

▶

b Balance at the end of the previous year .....

c Additions:

(1) Contributions deposited during the year .....

(2) Dividends and credits .....

(3) Interest credited during the year .....

(4) Transferred from separate account .....

(5) Other (specify below) .....

▶

(6) Total additions .....

d Total of balance and additions (add b and c*(6)*) .....

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year .....

(2) Administration charge made by carrier .....

(3) Transferred to separate account .....

(4) Other (specify below) .....

▶

(5) Total deductions .....

f Balance at the end of the current year (subtract e*(5)* from d) .....

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	**(b)**	Dental	**(c)**	Vision	**(d)**	X Life Insurance
(e)	Temporary disability (accident and sickness)	**(f)**	Long-term disability	**(g)**	Supplemental unemployment	**(h)**	Prescription drug
(i)	Stop loss (large deductible)	**(j)**	HMO contract	**(k)**	PPO contract	**(l)**	Indemnity contract
(m)	Other (specify below)						

▶

8 Experience-rated contracts

a Premiums:

(1) Amount received .....

(2) Increase (decrease) in amount due but unpaid .....

(3) Increase (decrease) in unearned premium reserve .....

(4) Earned *((1) + (2) - (3))* .....

b Benefit charges:

(1) Claims paid .....

(2) Increase (decrease) in claim reserves .....

(3) Incurred claims (add *(1)* and *(2)*) .....

(4) Claims charged .....

Official Use Only

c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions .....

(B) Administrative service or other fees .....

(C) Other specific acquisition costs .....

(D) Other expenses .....

(E) Taxes .....

(F) Charges for risks or other contingencies

(G) Other retention charges .....

(H) Total retention .....

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.) ...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement .....

(2) Claim reserves .....

(3) Other reserves .....

e Dividends or retroactive rate refunds due.
(Do not include amount entered in c(2).) .....

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier 1019403

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount .....
Specify nature of costs below

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2003

A Name of plan
INEEL LIFE INSURANCE PLAN

B Three-digit plan number ▶ 503

C Plan sponsor's name as shown on line 2a of Form 5500
BECHTEL BWXT IDAHO, LLC

D **Employer Identification Number**
94 3323797

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions**

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier
PRUDENTIAL FINANCIAL

(b) EIN 22 1211670 (c) NAIC code 68241

(d) Contract or identification number 23750-1

(e) Approximate number of persons covered at end of policy or contract year 5670

Policy or contract year (f) From 01 01 2002 (g) To 12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

	Total amount of commissions paid	Total fees paid / amount
Totals	0	0

0 5 0 2 A A 0 1 0 S

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★U.S. GOVERNMENT PRINTING OFFICE:2003-497-704

Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

Official Use Only

Part II **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates

▶

b Premiums paid to carrier .....

c Premiums due but unpaid at the end of the year .....

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....

Specify nature of costs

▶

e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)

▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ..... ▶

Official Use Only

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

(1) deposit administration (2) immediate participation guarantee (3) guaranteed investment

(4) other (specify below)

▶

b Balance at the end of the previous year .....

c Additions:

(1) Contributions deposited during the year .....

(2) Dividends and credits .....

(3) Interest credited during the year .....

(4) Transferred from separate account .....

(5) Other (specify below) .....

▶

(6) Total additions .....

d Total of balance and additions (add b and c(6)) .....

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year .....

(2) Administration charge made by carrier .....

(3) Transferred to separate account .....

(4) Other (specify below) .....

▶

(5) Total deductions .....

f Balance at the end of the current year (subtract e(5) from d) .....

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	Dental	(c)	Vision	(d)	X	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	Supplemental unemployment	(h)		Prescription drug
(i)	Stop loss (large deductible)	(j)	HMO contract	(k)	PPO contract	(l)		Indemnity contract
(m)	Other (specify below)							

▶

8 Experience-rated contracts

a Premiums:		
(1) Amount received	1680999	
(2) Increase (decrease) in amount due but unpaid	-171476	
(3) Increase (decrease) in unearned premium reserve		
(4) Earned ((1) + (2) - (3))		1509523
b Benefit charges:		
(1) Claims paid	1579085	
(2) Increase (decrease) in claim reserves	57837	
(3) Incurred claims (add (1) and (2))		1636922
(4) Claims charged		1636922

0 5 0 2 A A 0 5 0 W

Official Use Only

c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions .....

(B) Administrative service or other fees .....

(C) Other specific acquisition costs .....

(D) Other expenses ..... -37015

(E) Taxes 50481

(F) Charges for risks or other contingencies 25959

(G) Other retention charges .....

(H) Total retention 39425

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.) ...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement .....

(2) Claim reserves .....

(3) Other reserves .....

e Dividends or retroactive rate refunds due.
(Do not include amount entered in c(2).) .....

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier .....

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount .....
Specify nature of costs below

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2003

A Name of plan
INEEL LIFE INSURANCE PLAN

B Three-digit plan number ▶ 503

C Plan sponsor's name as shown on line 2a of Form 5500
BECHTEL BWXT IDAHO, LLC

D **Employer Identification Number**
94 3323797

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions**

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier
PRUDENTIAL FINANCIAL

(b) EIN 22 1211670 (c) NAIC code 68241

(d) Contract or identification number 23750-3

(e) Approximate number of persons covered at end of policy or contract year 8898

Policy or contract year (f) From 01 01 2002 (g) To 12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

	Total amount of commissions paid	Total fees paid / amount
Totals	0	0

0 5 0 2 A A 0 1 0 S

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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

Official Use Only

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates

▶

b Premiums paid to carrier .....

c Premiums due but unpaid at the end of the year .....

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....

Specify nature of costs

▶

e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)

▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ..... ▶

Official Use Only

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

(1) deposit administration (2) immediate participation guarantee (3) guaranteed investment

(4) other (specify below)

▶

b Balance at the end of the previous year .....

c Additions:

(1) Contributions deposited during the year .....

(2) Dividends and credits .....

(3) Interest credited during the year .....

(4) Transferred from separate account .....

(5) Other (specify below) .....

▶

(6) Total additions .....

d Total of balance and additions (add **b** and **c***(6)*) .....

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year .....

(2) Administration charge made by carrier .....

(3) Transferred to separate account .....

(4) Other (specify below) .....

▶

(5) Total deductions .....

f Balance at the end of the current year (subtract **e***(5)* from **d**) .....

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	Dental	(c)	Vision	(d)	X	Life Insurance
(e)	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	Supplemental unemployment	(h)		Prescription drug
(i)	Stop loss (large deductible)	(j)	HMO contract	(k)	PPO contract	(l)		Indemnity contract
(m)	Other (specify below)							

▶

8 Experience-rated contracts

a Premiums:

(1) Amount received .....

(2) Increase (decrease) in amount due but unpaid .....

(3) Increase (decrease) in unearned premium reserve .....

(4) Earned *((1) + (2) - (3))* .....

b Benefit charges:

(1) Claims paid .....

(2) Increase (decrease) in claim reserves .....

(3) Incurred claims (add *(1)* and *(2)*) .....

(4) Claims charged .....

Official Use Only

c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions .....

(B) Administrative service or other fees .....

(C) Other specific acquisition costs .....

(D) Other expenses .....

(E) Taxes .....

(F) Charges for risks or other contingencies

(G) Other retention charges .....

(H) Total retention .....

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.) ...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement .....

(2) Claim reserves .....

(3) Other reserves .....

e Dividends or retroactive rate refunds due.
(Do not include amount entered in c(2).) .....

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier 1596029

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount .....
Specify nature of costs below

Form **5500**

Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only

OMB Nos. 1210-0110 / 1210-0089

2002

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning 10 01 2002 **and ending** 09 30 2003

A This return/report is for:
- (1) ☐ a multiemployer plan;
- (2) ☒ a single-employer plan (other than a multiple-employer plan);
- (3) ☐ a multiple-employer plan; or
- (4) ☐ a DFE (specify) .....

B This return/report is:
- (1) ☐ the first return/report filed for the plan;
- (2) ☐ an amended return/report;
- (3) ☐ the final return/report filed for the plan;
- (4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ..... ▶ ☐

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ..... ▶ ☐

Part II Basic Plan Information -- enter all requested information.

1a Name of plan

INEEL SHORT TERM DISABILITY PLAN

1b Three-digit plan number (PN) ▶ 508

1c Effective date of plan 08 01 1992

Caution: *A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.*

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator

SIGN HERE ▶ Candace F. Wilkinson Date 04 20 2004

Type or print name of individual signing as plan administrator

a CANDACE F WILKINSON

Signature of employer/plan sponsor/DFE

SIGN HERE ▶ Candace F. Wilkinson Date 04 20 2004

Type or print name of individual signing as employer, plan sponsor or DFE

b CANDACE F WILKINSON

Official Use Only

2a Plan sponsor's name and address (employer, if for single-employer plan) (Address should include room or suite no.)

1) BECHTEL BWXT IDAHO, LLC

2) C/O CANDACE F WILKINSON

3) PO BOX 1625 1955 FREEMONT AVE

4) IDAHO FALLS

5) ID 83415-3200

6)

7)

8)

9)

2b Employer Identification Number (EIN) 94 3323797

2c Sponsor's telephone number 208 526 0066

2d Business code (see instructions) 541990

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")

1) SAME

2) C/O

3)

4)

5)

6)

7)

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

0 1 0 2 A A 0 2 0 P

Official Use Only

5 Preparer information (optional)

a Name (including firm name, if applicable) and address

1)

2)

3)

b EIN

4)

5)

c Telephone number

6)

6 Total number of participants at the beginning of the plan year 5053

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants 4969

b Retired or separated participants receiving benefits .....

c Other retired or separated participants entitled to future benefits .....

d Subtotal. Add lines **7a**, **7b**, and **7c** 4969

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....

f Total. Add lines **7d** and **7e** 4969

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....

I If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) .....

Official Use Only

8 Benefits provided under the plan (complete 8a and 8b, as applicable)

a Pension benefits (check this box if the plan provides pension benefits and enter below the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions):

b X Welfare benefits (check this box if the plan provides welfare benefits and enter below the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

4F

9a Plan funding arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) X Insurance

(2) Code section 412(i) insurance contracts

(3) Trust

(4) General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

1) R (Retirement Plan Information)

2) T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ..... ▶

3) B (Actuarial Information)

4) E (ESOP Annual Information)

5) SSA (Separated Vested Participant Information)

b Financial Schedules

1) H (Financial Information)

2) I (Financial Information--Small Plan)

3) X 001 A (Insurance Information)

4) C (Service Provider Information)

5) D (DFE/Participating Plan Information)

6) G (Financial Transaction Schedules)

7) P (Trust Fiduciary Information)

0 1 0 2 A A 0 4 0 R

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar plan year 2002 or fiscal plan year beginning 10 01 2002 and ending 09 30 2003

A Name of plan
INEEL SHORT TERM DISABILITY PLAN

B Three-digit plan number ▶ 508

C Plan sponsor's name as shown on line 2a of Form 5500
BECHTEL BWXT IDAHO, LLC

D Employer Identification Number
94 3323797

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions**

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier
CIGNA LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN 23 1503749 **(c)** NAIC code 65498

(d) Contract or identification number LK 008044

(e) Approximate number of persons covered at end of policy or contract year 5189

Policy or contract year **(f)** From 01 01 2002 **(g)** To 12 31 2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals	Total amount of commissions paid	Total fees paid / amount
	0	0

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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid

(c) Fees paid / Amount

(e) Organization code

(d) Fees paid / Purpose

Official Use Only

Part II **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates

▶

b Premiums paid to carrier .....

c Premiums due but unpaid at the end of the year .....

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount .....

Specify nature of costs

▶

e Type of contract (1) individual policies (2) group deferred annuity

(3) other (specify below)

▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ..... ▶

Official Use Only

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract

(1) deposit administration (2) immediate participation guarantee (3) guaranteed investment

(4) other (specify below)

▶

b Balance at the end of the previous year .....

c Additions:

(1) Contributions deposited during the year .....

(2) Dividends and credits .....

(3) Interest credited during the year .....

(4) Transferred from separate account .....

(5) Other (specify below) .....

▶

(6) Total additions .....

d Total of balance and additions (add b and c(6)) .....

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year .....

(2) Administration charge made by carrier .....

(3) Transferred to separate account .....

(4) Other (specify below) .....

▶

(5) Total deductions .....

f Balance at the end of the current year (subtract e(5) from d) .....

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

(a)	Health (other than dental or vision)	(b)	Dental	(c)	Vision	(d)	Life Insurance
(e) X	Temporary disability (accident and sickness)	(f)	Long-term disability	(g)	Supplemental unemployment	(h)	Prescription drug
(i)	Stop loss (large deductible)	(j)	HMO contract	(k)	PPO contract	(l)	Indemnity contract
(m)	Other (specify below)						

▶

8 Experience-rated contracts

a Premiums:

(1) Amount received .....

(2) Increase (decrease) in amount due but unpaid .....

(3) Increase (decrease) in unearned premium reserve .....

(4) Earned *((1) + (2) - (3))* .....

b Benefit charges:

(1) Claims paid .....

(2) Increase (decrease) in claim reserves .....

(3) Incurred claims (add *(1)* and *(2)*) .....

(4) Claims charged .....

Official Use Only

c Remainder of premium:

(1) Retention charges (on an accrual basis) --

(A) Commissions .....

(B) Administrative service or other fees .....

(C) Other specific acquisition costs .....

(D) Other expenses .....

(E) Taxes .....

(F) Charges for risks or other contingencies

(G) Other retention charges .....

(H) Total retention .....

(2) Dividends or retroactive rate refunds.

(These amounts were 1) paid in cash, or 2) credited.) ...

d Status of policyholder reserves at end of year:

(1) Amount held to provide benefits after retirement .....

(2) Claim reserves .....

(3) Other reserves .....

e Dividends or retroactive rate refunds due.
(Do not include amount entered in c(2).) .....

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier 2419467

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount .....
Specify nature of costs below